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PSYCHOSOCIAL CARE IN THE SYRIAN REFUGEE CRISIS

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By Miller A. Richmond

A thesis presented in partial fulfillment of the requirements for completion of
the Bachelor of Arts degree in International Studies
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ABSTRACT

MILLER RICHMOND: Psychosocial Care in the Syrian Refugee Crisis (Under the direction of Dr. Katherine Centellas)

The Syrian civil war created millions of refugees who are internally displaced across Syria and in surrounding host countries. The use of violence and forms of warfare against the Geneva Convention make this crisis particularly traumatic for civilians, leading to high rates of PTSD and depression among the refugee population. Relying on concepts of structural violence and the ecology of health, I justify the use of a psychosocial framework to build refugee crisis response in Jordan. I performed ethnographic fieldwork to collect data in the form of stakeholder and care provider interviews and training manuals, and I analyzed and critiqued issues around implementing the psychosocial care framework. In this study, the results fell into four, broad categories: the stigma associated with mental illness and stress-related conditions, the view of mental health and psychosocial care as non-traditional medicine, the sheer scale of psychosocial care needed, and legal issues of providing these services in Jordan. These results led to conclusions that psychosocial care implementation will likely require cultural perceptions around mental illness to change and a large commitment by host countries and the international community must be made. New innovations in medical technology and better understanding around mental illness will ease and improve the implementation of a psychosocial care infrastructure that reduces suffering from mental illness.

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I. Introduction

The Syrian crisis has been called “the worst humanitarian crisis since World War II” and the “biggest humanitarian emergency of our era” due to the violence inflicted upon civilians for over six years (Tobia, 2015 and Peralta, 2014). Significant recovery is needed for all Syrians, especially children who have been exposed to violence and lost years of schooling. All host countries and the international community should facilitate safe processing of the displacement, torture, and trauma refugees have experienced. Thus, I argue in this study that integrated mental health and psychosocial care is the proper method of alleviating suffering among Syrian refugees in Jordan. Through analysis of interviews with stakeholders and training documents, I discuss the issues surrounding the implementation of this program, as well as new forms of care developing as a result of this crisis.

Four months in Jordan in the fall of 2015 studying in refugee camps, meeting with NGOs, and talking with refugees served to solidify this idea. I completed a previous study in Jordan focusing on the treatment of mental illness in Syrian refugee women with diabetes (Richmond, 2015). I was immersed in researching complex issues that taught me to appreciate nuance and contextualization while being distrustful of research that focused on the black and white. I learned both what to do and what not to do when researching and writing, and I especially learned that I wanted to make my thesis an expansion of that topic. More than anything, the previous research project showed me the lack of support for vulnerable populations in international crisis response frameworks. I saw rates of clinical psychiatric distress among Syrian refugees estimated as high as 65% and only as low as

33.5%. My experiences with Syrian refugees led me to believe that the true instance of PTSD was closer to the higher rate (Alpak et al., 2015, Nassan et al., 2015). A study from the International Medical Corps and WHO included 7,579 Syrian refugee respondents in Jordan, split evenly between refugees residing inside camps and outside camps (2013, p.32). It found high rates of suffering from symptoms of mental illness, as discussed in the following quote:

When reporting mental health symptoms present ‘all of the time’ in the last 2 weeks, 15.1% of respondents felt so afraid that nothing could calm them down; 28.4% felt so angry that nothing could calm them down; 25.6% felt so uninterested in things that they used to like; 26.3% felt so hopeless that they did not want to carry on living; 38.1% felt so severely upset about the conflict that they tried to avoid places, people, conversations or activities that reminded them of such events; and 18.8% felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset.

Reading studies such as this one, and listening to Syrian refugees describing symptoms exactly like these propelled me to focus my senior thesis in this area.

Many studies on trauma, especially in regards to psychological trauma, are based in Western countries far from the refugees’ country of origin and are very rarely contextualized (Pedersen, 2002). Older studies separate the treatment of trauma and daily stressors arguing that they cannot be treated through the same process. More recently, studies show that an integrated approach of specialist mental health care integrated with a

broader psychosocial framework is more effective in helping refugees return to a life of normalcy (Miller & Rasmussen, 2009). Concerning amounts of daily stress and trauma occur during the refugee experience, and there is a bio-psycho-social- classification pathway with many inputs that contribute to an immense level of suffering. First described in detail in “On Suffering and Structural Violence: A View from Below,” Paul Farmer’s pathway, called structural violence, has changed the view of crisis response, health care, and development in the 21st century. It includes biological factors, but also the economy, access to food, registration/work permit status, and religious beliefs (Farmer 1996). Primarily, the concept highlights how poverty, poor health, and discrimination do not only combine to increase suffering, but they also reinforce each other causing a dangerous cycle that cannot be improved without an intervention that addresses all of these issues. Acknowledging this concept, the integrated mental health and psychosocial support (MHPSS) framework seeks to treat mental illness through addressing all pertinent avenues of care available. I seek to answer questions around implementing this framework, social and economic barriers to care, and stigma around mental illness.

II. Methodology

This study utilizes a mixed-methods approach to discuss psychosocial care in the Syrian Civil War, with a focus on the Jordanian healthcare system where many Syrians have fled throughout the conflict. In order to do this effectively, the problems of establishing, accessing, and completing psychosocial care will be highlighted with care taken to analyze emerging new responses to mental health issues in this crisis. I collected data through interviews with various stakeholders from the Jordanian Ministry of Health (MOH), non-governmental organizations (NGOs), and doctors working at private and public clinics in near Mafraq, Jordan and Amman, Jordan. These interviews were largely conducted in English, as that is the language of medicine in Jordan. There were several times I used Arabic during the interview in a follow-up question or by the doctors to clarify statements and provide a better picture of the situation. Each interview typically lasted 30-45 minutes, and all but one were conducted in-person or over video chat. One practitioner requested a written interview, as she did not want to take time away from patients. Previously conducted interviews in Arabic with Syrian refugees greatly shaped this study, but results from those interviews are not included in this work. In most instances, I selected interviewees who treated Syrian refugees in a medical setting, with a mix of primary care physicians and specialists. Three interviewees were chosen because they served as central planners for the MOH or an NGO providing medical services in the area. The MOH is the central planner for the Jordanian health system and the crisis response, though the entire system is quite unorganized. Consequently, I used the snowball sampling method, which does not allow for a randomized study, but it has been shown to provide a

“sampling of natural interactional units” (Biernacki & Waldorf p. 141, 1981).

Acknowledging that my interviews would not be representative of the entire experience with this method, I actively searched for and found 3-4 interviewees who did not work for the MOH and could lend a more holistic view to my study. Except when permission is given, NGOs will not be named as a condition of the interview.

Statistics on mental health, especially in a crisis situation, are estimates of the true mental health burden on a population. Thus, this study will primarily be from a qualitative perspective; however, some data on mental health will be used to understand the scope of the crisis. The qualitative approach mandates that people with mental illness or stress are able to retain their dignity in the study. In his paper entitled, *Global Mental Health: A Failure*, Kleinman stated that “ground zero” in mental health is not in statistics, though they continually show rising rates of mental illness and stagnant funding, but instead, “ground zero is the routine local condition of people with mental illness in communities, networks, and families. It is their pain and suffering” (2009, 603). This study works in the aforementioned ground zero—it focuses on the social and medical structures in place that can improve or hinder the Syrian refugee’s experience of mental illness in Jordan.

With regards to the method of qualitative analysis, I chose the ethnographical approach, as I worked to better understand the issues around mental health and psychosocial care from a local perspective. It also recognizes my presence in the research process and allows a non-medical practitioner such as myself to let the interviewee lead the interview process through open-ended questions. Kleinman and Benson define ethnography in the medical field below, and I took a similar approach with my interviewees by listening to their stories and how they perceive the world around them.

Ethnography emphasizes engagement with others and with the practices that people undertake in their local worlds. It also emphasizes the ambivalence that many people feel as a result of being between worlds ... ethnography eschews the technical mastery that the term “competency” suggests. Anthropologists and clinicians share a common belief—i.e., the primacy of experience. The clinician, as an anthropologist of sorts, can empathize with the lived experience of the patient's illness, and try to understand the illness as the patient understands, feels, perceives, and responds to it (2006, p. 1674).

Though terms like Post-Traumatic Stress Disorder (PTSD) and depression will be used for clarity, this study primarily focuses on a local conception of mental illness and stress stemming from exposure to violence and torture, displacement from home, and a fracturing of social structures. The conceptual framework for psychosocial care of de Jong and Jordans discussed in the next section is specific enough to affect change while allowing each implementation to apply this framework “in an eclectic way and molds them (it) to the requirements of the specific sociocultural context” (de Jong 2002, 81). Most importantly, psychosocial care will be mentioned throughout this study. The reader should not envision a psychiatrist and a patient sitting in a room exclusively but instead see religious leaders, community members, nurses, active listeners, and social workers. There are multiple, interdisciplinary approaches to the same goal—mental health, empowerment, and community building.

III. Global Mental Health and Psychosocial Care

In their chapter, entitled “The Unique Challenges of Mental Health and MDRTB (multi-drug resistant tuberculosis),” Becker et al., argue mental health is an “odd case” that “has an uneasy relationship with traditional international health and global health discourses” (2013, p. 213). Mental health makes up about 12 to 15 percent of the entire global burden of disease, more than tuberculosis or cancer, but it only receives a small portion of the international community’s attention (Murray & Lopez, 1996). The global mental health movement also suffers from two critical faults: universalization and medicalization. Becker et al., also discuss the issues around a Western approach to medicine that takes a one-size-fits-all approach:

Estimates based on universalizing criteria for mental disorders, such as those listed in the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V)—the American Psychiatric Associations widely used classification manual—have uncertain validity within populations other than those for which they were developed (mainly European and American populations). These diagnostic criteria have potentially limited clinical utility across diverse cultural and social contexts, given then phenomenologic variation in psychiatric presentation and the culture-specific rhetoric used to signal distress (2013, p. 215).

Closely related, medicalization is the tricky concept of placing medical terms on biological conditions, leading to criticism of placing all life experiences in a medical box. Kleinman

argues that medicalization can give “the sufferer the sick role, medicalization can stigmatize as well as protect; it can institute a misguided search for magic bullets of complex social problems; and it can obfuscate the political and economic problems that influence these behaviors” (1997, p. 38). Understanding both of these faults, I avoided Western definitions of mental health. It is well documented that Western classifications project an “underlying cultural psychology” of the medical professionals who create them, and they largely serve to marginalize the “Other” through these classifications (Gaines, 1992, p.3).

Mental illness also causes a compounding and reinforcing effect on individuals’ overall health. In addition to the suffering directly caused by mental illness, even mild forms of PTSD or depression significantly increase the likelihood of cardiovascular issues, diabetes, and suicide. Mental illness also makes individuals more susceptible to diseases, as it can decrease the effectiveness of the immune system (Prince et al., 2007). If left untreated, mental illness is unrelenting in the suffering it causes through the rupturing of social ties, lost wages, and stigmatization (Kawachi & Berkman, 2001). It truly can become a chronic, debilitating disease.

Psychosocial and community mental health programs have been shown to work throughout the world, particularly in response to humanitarian emergencies, political violence, and refugee crises (Becker, 2013, p. 219; Mollica et al., 2004; Porter & Haslam, 2005; Betancourt & Khan, 2008; Tol et al., 2011). Thus, this study will use foundational concepts of global mental health to analyze psychosocial care in the Syrian conflict.

The Psychosocial Care Framework

Psychosocial care is important to the long-term rebuilding of the Syrian state. The borders may look different and populations within the country have certainly shifted, but this study is concerned with what happens on a community level currently and post-crisis. Exposure to violence often leads to desensitization to acts of human rights abuses and making someone more prone to commit or be comfortable with his/her society pursuing violent consequences to resolutions. Thus, investing in community building through psychosocial care on a large scale can mitigate the effects of the Syrian Civil War, improve reconciliation, and create a future with less violence. (Staub, 2006)

Psychosocial care is not easily defined. NGOs and the WHO typically place it under the broader umbrella term of mental health and psychosocial support, or MHPSS. It encompasses most common clinical therapies: individual therapy, group therapy, cognitive-behavior therapy, dyadic therapy and pharmacological therapy. Some traditional interventions must be performed by a licensed physician in refugee host countries, but psychosocial care also includes informal group or individual educational sessions meant to lessen stress on refugees, as will be discussed later. Additionally, this type of care ensures that the social and real context in which the patient lives is not excluded. The health care service provider takes into account social factors that affect the patients' wellbeing, such as spirituality, gender, socioeconomic status, documentation status, or access to food or hygiene (Engel, 1989). From a similar perspective, a psychosocial focus on care may be better defined by the outcomes that it works to create for the patients. It hopes to restore self-esteem and provide stability for the patient, while also treating the patient for PTSD or depression due to events that have been witnessed or experienced. Outcome and patient-

focused interventions improve the lives of individuals, but collectively they are important in improving the stability of a community (Carlson & Bultz, 2004). As will be discussed later, many mental health programs working with Syrian refugees struggle to meet the demand for care. Properly implemented, community-based models of psychosocial care scale up their impact by utilizing innovative, group-based interventions that reserve specialist and time-intensive care for the patients who need it the most (Eaton et al., 2011). Jordans et., al created a “multi-layered psychosocial care system” for areas in lower or middle income countries who have undergone political violence and may lack a complete MHPSS system for its population (2010). As can be seen in Figure 1 below, first-line prevention of mental illness and stress related disorders relies upon political and economic stability, education opportunities and strong health systems. During the Syrian civil war and other crises, this social support infrastructure breaks down, requiring an increase of the various types of care higher up the pyramid. The next four levels show an increase in the level of care coupled with a decrease of people eligible to access that care. The backbone of this tiered psychosocial care system is group-based therapy in the form of trained and untrained professionals. Resilience groups allow individuals to discuss traumatic events with others who may have suffered with them. When screening shows that a patient may need a higher level of care in basic, group setting, “para-professional group care” is utilized to provide more structured care without reserving the time for a fully-licensed professional unless indicated. Most importantly, this model encourages active screening throughout all interventions at every level, which reduces the number of individuals at every level whose illnesses are left untreated. Most studies, such as Jordans,

on this subject have been exclusively focused on children; however, a similar, integrated model discussed below will show ability to work among all age groups.

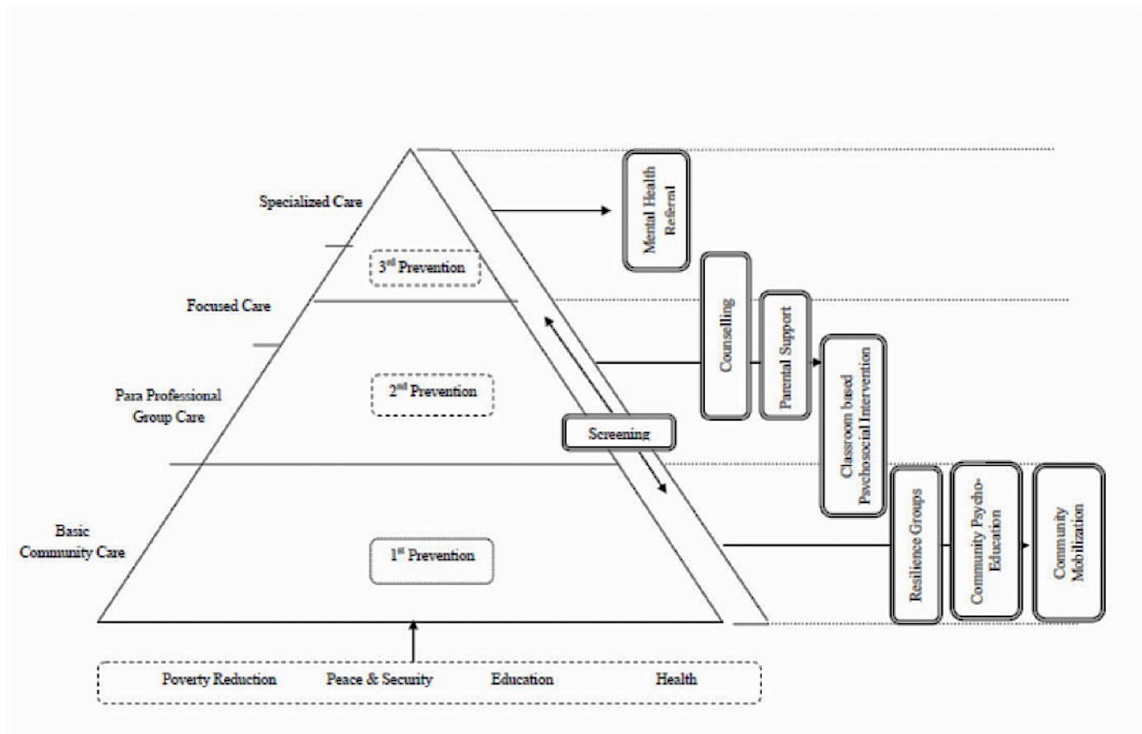


Figure 1: Retrieved from Jordans et al., (2010)

A similar pyramid model by Joop de Jong (2002) conceptually builds on the previous model by describing three levels of intervention for psychosocial care for low-resource areas. The largest and lowest level, “society-at-large,” is important in the prevention of crises and traumatic experiences that cause stress on a population. This also relies on governments, non-governmental organizations, and policy to instill an understanding of mental health that reduces stigma around mental illness. The middle level refers to interventions at the community level, which include “the provision of safety and shelter, empowerment of the community, public education, and capacity building” (de Jong 2002, 65). This level of treatment relies on psychosocial group therapy conducted by community

health workers or self-help groups that allow community members who experienced similar traumatic events to rely on each other. It is important to note that the community level relies on other refugees and low-skilled health workers in order to extend the reach of the intervention to treat as many individuals as possible. Group based interventions during events such as refugee crises allow the high demand on the health system to be spread throughout the system, instead of only on a few mental health professionals or facilities. Similarly, the third and highest level of intervention, family and individual, is oftentimes reserved by the UNHCR, MOH, or other NGOs for refugees with the most pressing mental health needs, such as torture victims or children with developmental issues. The high exposure to violence and lack of specialized mental health resources prevents every refugee from accessing care where a trained psychological health professional is present (de Jong 2002, p. 66-78).

The primary care provider is located between the community and individual (provided by a specialist) treatment levels on the pyramids by both de Jong and Jordans. In many low and middle-income countries, primary care providers (PCP) are not expected to provide mental health care, and the PCP and a specialized mental healthcare provider should not necessarily be in the same category. At the same time, this separation speaks to the gap between what are traditionally seen as medical issues and mental health issues. Despite this, the WHO released guidelines to help PCPs treat patients with mental health illnesses, and PCPs are an important access point for a region without many specialized mental health providers (Eaton et al., 2011). Much of the discussion in this paper will be on the efficacy and accessibility of targeted treatment, but this resource-intensive care relies

on community and PCP psychosocial care in a crisis to reduce demand and stress on the existing health care infrastructure.

IV. The Syrian Conflict and Violence

With brutality that foreshadowed the next six years of violence, the Syrian Civil War began in January 2011 with scattered protests spurred by the Arab Spring movement sweeping the region at the time. It was not until fifteen youths, or schoolchildren depending on reports, were arrested in the southwestern city of Daraa for painting anti-regime graffiti on walls that the crisis exploded into violence. These youth were tortured and beaten by the police, which poured fuel onto the protests as opposition groups found more people willing to join in the anti-regime movement. The regime passed the point of no return as they cracked down fiercely by beating and arresting protesters in the street, and eventually, firing into crowds. This event helped transform the movement from protests to a violent civil war that continues today. Lynch, Freelon, and Aday (2014) argue the Syrian movement was based on pan-Arabism and anti-corruption, similar to Arab Spring protests that resulted in a change of power. Consequently, the common belief that Syria and the Assad regime would collapse similar to Tunisia and Egypt was not necessarily wrong at the time, but it missed the depth of the sectarianism in Syria and the length to which the Assad regime would go to hold onto power.



Graffiti from Daraa saying "Your turn doctor" (Asher- Schapiro, 2015)

The regime crackdown on protests in the city of Daraa is the “spark that lit the Syrian flame” of civil war (Sterling, 2012). The Assad regime is a minority-Alawite sect ruling a majority Sunni populace, and Daraa, a city that is largely Sunni but historically close to the regime, is a case study in the tensions that were harbored for years against the Assad regime across Syria in Sunni-majority areas. The Assad family does not have a record of upholding human rights law when they feel that their power is threatened. Long before the current civil war, the Syrian people could be imprisoned on political charges without access to lawyers and prisoners regularly disappeared without a trace (Ghadry, 2005). The most disturbing example of mass murder was the Hama Massacre in February 1982. In response to a Muslim Brotherhood movement against the regime, Rifat al-Assad, Bashar’s uncle, leveled the city of Hama from a hill nearby. The estimates of people killed during the shelling range from 10,000- 30,000, and the regime did not provide money to

the city to rebuild for a decade (Lawson, 2004). Placing the crackdown after protests began in 2011 into this historical context shows that the younger, supposedly more liberal, Bashar al-Assad is not unlike his father. He will do anything that is necessary to maintain his authority, as can be seen in the atrocities described below.

The sustained, violent tactics of actors in the Syrian Civil War over the past six years are brutal on the general population, with comparisons commonly being made to the Rwandan genocide and the Holocaust (Landler, 2014). Currently, the actors are numerous and changing everyday, but the landscape of the conflict can be classified into three main categories: Islamist groups (i.e. ISIS, Al-Qaeda, Jabhat al-Nusra), secular rebels (Free Syrian Army and others), and the Syrian regime itself. All of these groups contribute to the flow of refugees into surrounding countries and the traumatic experiences they bring with them through physical and emotional scars in the form of lost limbs, PTSD, and depression. ISIS and other Islamist groups have taken over large portions of the country where they have enacted public executions, enslaved ethnic groups, and conducted killings resulting in mass graves throughout its territory (Shaheen, 2016). The secular opposition groups have often been accused of being Islamist, and they have also been shown on social media beheading enemies (CBS Article/HRW). The Assad regime has the most power of these three categories of groups due to prison and defense infrastructure, chemical weapon stores, and a functional air force. Furthermore, the Assad regime receives military and political support from external actors. The Russian UN delegation continually maintains that human rights abuses are not occurring, and it demands that any plan to resolve the conflict includes the Assad regime's hold on power. Though trauma and violence come from all groups in the Syrian conflict, the regime has contributed much of the terror that has

occurred in Syria over the past 6 years. Below, I discuss the use of mass imprisonment and torture, gas attacks, bombing, and targeting of hospitals and health workers as some of the major ways that the regime and associated powers have caused immense physical, emotional, and mental harm on the refugees that are in need of proper psychosocial care.

A recent Amnesty International report showed that 13,000 people were systematically hanged in Saydnaya prison in Syria by the regime since 2011. This typically took place in mass hangings in the middle of the night after a “one to two minute military trial” (Amnesty, 2017). Prisoners were regularly beaten and deprived of food, while also being forced to sexually abuse each other. Prior Amnesty reports show that it is likely that this is happening across the country in prisons run by the Syrian regime. Police brutality also occurs outside of prisons, as there are many reported instances of dissenters disappearing from their homes after disagreeing with the regime (Amnesty, 2017). Though it is difficult to quantify these events, there is immense stress in living with the threat of extrajudicial imprisonment and killings constantly on one’s mind.

Another method of waging war, chemical attacks, is not nearly as widespread as other attacks, but the brutality of chemical warfare multiplies the effect much further than the people that it injures or kills. Chemical attacks have “psychological, social, and political consequences,” and after an attack, “the general level of malaise, fear, and anxiety may remain high for years, exacerbating pre-existing psychiatric disorders and further heightening the risk of mass sociogenic illness” (Wessely, Hyams & Bartholomew, 2001). This makes the effects of the 2013 chemical attack by the Assad regime in Ghouta, Syria a long-term psychological burden to many refugees. The number of people killed in this attack has not been determined, but Doctors Without Borders reports that they received

3600 patients at their hospitals with “neurotoxic symptoms” in three hours (Doctors Without Borders, 2013). Accurate statistics on chemical weapon usage or who possesses them during the conflict has been difficult to determine, but based on the impact of prior instances of real and/or suspected cases of gas attacks in Iraq, the population feels stress for years afterwards (Wessely et al., 2001). The Khan Sheikhoun chemical weapons attack on April 4, 2017 killed at least 80 and injured around 571 recently brought this method of war back into public discourse (BBC, 2017). International outrage is at its highest after chemical weapons attacks, but though President Trump reflexively launched missiles in a small airstrike on the regime, it is not clear whether this event will provoke a long-term change in United States policy.

The most broad, indiscriminate tactic has been the use of bombs dropped from planes and helicopters. The majority of these bombs were deployed by the Syrian Army against civilians; however, it must be noted that there have been attacks carried out by Russia, Turkey, the United States, and several other nations during the course of this conflict that also killed civilians (Amnesty, 2016). In keeping with this study’s refugee-centered approach, the outcomes of these attacks on civilians are focused on more so than the events that led them to occur. Many of these attacks are “barrel bombs” used to inflict terror upon a population. They are described as airborne improvised explosive devices, and the bombs are packed with shrapnel and occasionally napalm or chlorine to indiscriminately maim and kill people in the area. Thousands of these bombings have caused a massive loss of life. The UN and other organizations conservatively estimated in April 2016 that 400,000 people had been killed in the conflict, with the majority of them occurring due to bombs (UNHCR, 2017). Particularly brutal is the fact that many of these

bombs are dropped from close-range by helicopters aiming for civilian populated areas and hospitals, or they are launched as mortars from nearby (PHR, 2015). The closeness of the violence leaves few safe spaces for Syrian civilians to flee to, and it adds to the stress of living under wartime conditions.

Targeting healthcare workers and infrastructure has been a tactic of the Assad regime throughout the civil war. Physicians for Human Rights (PHR) stated two years ago that, “since the conflict began in 2011, PHR has documented the killings of 679 medical personnel, 95% of them perpetrated by government forces. Some personnel were killed in bombings of their hospitals or clinics; some were shot dead; at least 157 were executed or tortured to death” (PHR, 2015). This has led many Syrians remaining in the country to become fearful of visiting the hospitals for care, if the hospitals are able to remain open at all (Amnesty, 2011). Below, Figure 2 summarizes the violence that is occurring in the Syrian conflict. It shows the high rate at which casualties increased during the crisis, the violent use of explosives as a means of war against children, and a decrease in health care workers and hospitals of over 50% in 4 years. All statistics detailed in the graphic are traumatic, against the Geneva Convention, and constitute war crimes, but I would like to call particular attention to the loss of health care workers for this study. Due to the Assad policy of destroying hospitals and the makeshift structures that attempt to replace them (some have resorted to moving underground), refugees often enter Jordan without accessing health care of any sort in a long time. Prior to the civil war, Syria did not possess the capacity to allow all mental health patients to be treated. Violent acts against health care workers exacerbate this issue, and it does not bode well for the long-term health of the Syrian people.

Fig. 2 Estimates of the number of deaths as a result of the current conflict in Syria (sources: CSIS 2013; Reuters 2014; Solomon 2013)

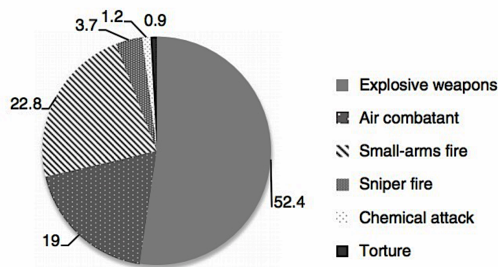
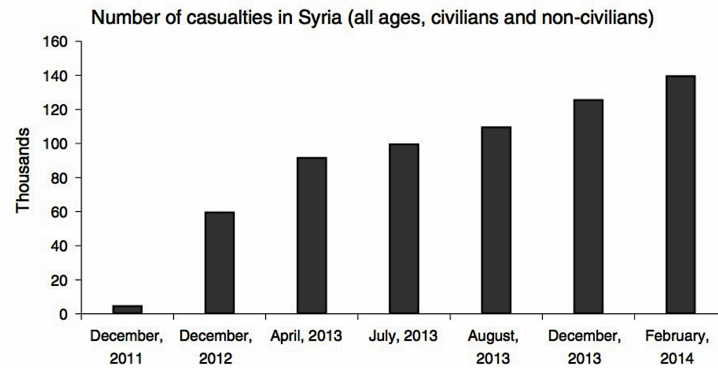


Fig. 3 Main causes of conflict-related deaths among Syrian children (%) (source: Salama and Dardagan 2013)

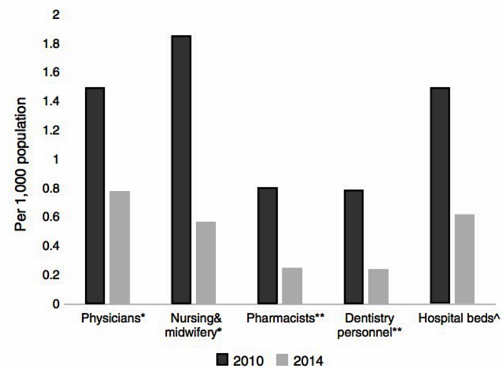


Figure 2: Retrieved from Taleb, et al. (2015)

Possibly the least directly violent but most impactful on the mental health and psychosocial wellbeing of Syrian refugees are the psychological effects of displacement. The stress of being removed from home and social support network is a tactic of war being used to weaken anti-government support and consolidate power. Displacement from one's home disrupts what Armelagos et al coined as the "ecological model of disease" (1978). It is similar to Farmer's bio-psycho-social pathway mentioned previously, but it addresses displacement specifically (Farmer, 1996). Pedersen best describes this model as being separated into "inorganic (i.e. temperature, humidity, oxygen pressure, ultraviolet and cosmic radiation, soil and water trace elements, etc.) organic (caloric intake, bacteria, protozoan, viral organisms, etc.) and cultural (i.e. ideological, symbolic, technological, and

social systems)” parts that all contribute to the health and wellbeing of an individual (1996, p. 746). This environment is altered in refugees, which exposes his/her ecology to new stresses that can have serious health effects. Traditional biological approaches to care do not include the cultural aspect of ecology, and the psychosocial approach works to include these factors into the overall care of the patient.

V. Syrian Refugee Crisis in Jordan

Prior to the Syrian refugee crisis, Jordan had already undergone two previous influxes of refugees from neighboring countries. The first occurred with the flight or expulsion of Palestinians from Palestine beginning in 1948. Today, the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNWRA) serves 2.1 million registered Palestinian refugees and continues to provide services in 10 Palestinian refugee camps (UNWRA, 2017). The relationship between the Jordanian government and Palestinians has been extremely contentious throughout history, as the Palestinians are often used as pawns in the international community. The Jordanian government gave support, work permits and social services over the years to Palestinians, but they also revoked citizenship en masse due to national and regional politics. From a societal standpoint, Jordanians of Palestinian origin have largely melded into the fabric of Jordan by now, though inequalities exist in the government jobs that Palestinians have access to (Al Oudat & Alshboul, 2010).



Baqaa Refugee Camp Clinic in September, 2015. Though originally a temporary camp, it has existed since 1968 outside of Amman, Jordan. (Photo by me)

The second, more recent, refugee influx into Jordan came from the United States invasion of Iraq in 2003. As of 2009, 700,000 Iraqi refugees had entered Jordan. The Jordanian government had similar contentious relationships with the new refugees due to terrorism concerns. For instance, Jordan banned adult males under 35 from entering the country after the 2005 Amman hotel terrorist attacks by Iraqis. Work permits from the Jordanian government have reportedly been reserved only for wealthy Iraqis. Additionally, Jordanians have accused Iraqis of crowding the housing market and placing stress on public services, especially water, education, and health care (Fagen, 2009).

As the Syrian Civil War began, Syrians flooded Jordanian borders just as Iraqi refugees had a decade earlier. In talking with Jordanians (some who were of Palestinian origin) around Amman, I was told that at first there were not many issues with Syrians coming into the country. The Syrians entering the country were from Daraa or surrounding areas near the Jordanian border. Many Syrians had family in Jordan, and the borders had been quite fluid in previous years due to Bedouin groups that lived in the area long before the border was established in 1921. As ISIS began to expand in Northern Syria and the Assad regime and allies began more bombing in the conflict, there was a large increase in Syrian refugees crossing into Jordan in 2013. This led to the establishment of several refugee camps throughout Jordan, and many NGOs entered the country to fill the gap in services that were either overcrowded or not provided by the Jordanian government.

I primarily focus on psychosocial care outside the camps that is available to the vast majority of refugees. News media, celebrities, and advocacy organizations often travel to refugee camps to advocate on the behalf of Syrian refugees, as can be seen below in the pictures of Ben Stiller and Angelia Jolie at Zaatari Camp with the UNHCR. This promotion is important, but it does not accurately portray the life of most Syrian refugees in Jordan. Similarly, more academic research occurs on Syrian refugees inside camps than outside of camps. Though 82,000 people live in Zaatari camp alone, the UNHCR estimates that 83% of refugees in Jordan live outside of camps. Most of the refugees have settled in urban or peri-urban areas in the northern Jordan and Amman (UNHCR, 2015). The experience of refugees in camps is very different than non-camp refugees. Within camps, there are more health services available, more police, and fewer non-Syrians that a refugee will come into

contact with. More research should be done on the differences in experiences of camp and non-camp refugees, especially feelings of safety vs. feelings of being trapped inside the camps. Through concentrating my interviews on individuals who work outside of camps, I more accurately portray the care that the average Syrian refugee in Jordan will access.



Zaatari Refugee Camp in October, 2015. Makeshift houses and streets go on for miles. (Photo taken by me)



Angelina Jolie visits Zaatari Camp (from UNHCR)

Estimates of the number of Syrian refugees residing in Jordan vary widely. The population of Jordan, before the Syrian Crisis in 2010, was around 6.5 million according to the government and the World Bank. According to the World Bank in 2015, the population swelled to 7.6 million over five years. A 2015 Jordanian government census that occurred while I was in Jordan shows a much higher growth rate during this time period. It recorded 9.5 million people in the country, including 2.9 million “guests” (Jordanian Department of Population Statistics, 2015). The government uses the term guests to refer to refugees of all types. Though the term appears as an extension of hospitality at first, the government uses the term because they do not recognize Syrian and Iraqi asylum seekers as refugees in international law. International law is out of the scope of this paper, but legal status has real repercussions, especially on health, for these individuals. Stevens best explains the Jordanian government’s legal view in the following quote:

Jordan raises some unique issues in the refugee law context: it has not ratified the 1951 UN Convention Relating to the Status of Refugees or the 1967 Protocol (Refugee Convention), and its domestic law on the treatment of asylum seekers and refugees is virtually non-existent. This is not to suggest, however, that it has adopted a wholly belligerent attitude towards refugees. In fact, the opposite is true. Jordan has accommodated refugees and displaced peoples for much of its history, and it is widely acclaimed for its generosity in hosting Palestinians in its territory. Where it can be said to fall short is in its refusal to regard any other group other than Palestinians as 'refugees'. Furthermore, the roles of the state, UNHCR and (I)NGOs in the provision of protection and aid, ... are not always clear (6, 2013).

This quote exemplifies, exactly, the feelings of many Jordanian government employees and officials at all levels that I spoke with. They were very proud of their willingness to open their country to millions of refugees, but were unwilling to risk sacrificing safety or political stability to harbor their neighbors, even with the demands of international law. The international community is unlikely to withdraw funding due to these issues of international law, as they are more concerned about the stability of the Jordanian government. This lack of rights or legal protection has led to high numbers of unregistered Syrian refugees.

Living as an undocumented person in a foreign country comes with stress and high incidences of PTSD (Woodward, Howard, & Wolffers, 2013). The 700,000 Syrian refugees formally registered with the UNHCR in Jordan caused the large increase in population that the official World Bank data shows. Formal registration as a refugee in Jordan comes with

more financial aid from some agencies and access to UNHCR health and educational resources, but the Jordanian government estimates that only half of the Syrian refugees in the country are registered (Jordanian Department of Population Statistics, 2015).

Conversations with several unregistered Syrian refugee women during my time in Jordan shed light on reasons they remained unregistered. Issues around legal status were of their utmost concern. The women were worried that if they registered, the Jordanian government would be able to find them and forcibly remove them if they wanted to. Similarly, they did not trust that the government would follow through on their policy of forgiving refugees who did not enter the country through legal border crossings. As can be seen by the legal analysis above, unregistered refugees' concerns about their freedom are reasonable; they do not have legal rights to live or work in Jordan. If they are unable to register as a refugee or receive a work permit, they are relegated to a shadowy existence of living and sustaining their families, which increases the stress of daily life as a "guest" in Jordan. The relationship between being undocumented and stress levels means psychosocial care must take this into account. Whether through safe spaces or more community outreach, clinics should recognize that they are not treating the people who need it most if they are not actively seeking unregistered refugees to utilize their clinic's services.

Although it is out of the scope of this paper, registration status affects mental health, stress levels, and education. During the three years since they left Syria, unregistered children I interacted with could not access formal schooling, which set them back years in reading and writing. In fact, a group of unregistered refugee women in the area taught younger children what they could, but many of the women were also uneducated. While

the majority of educational programs require registration, many NGOs (Doctors Without Borders, Caritas and others) do not ask for registration status when providing health services, though the largest, UNHCR, does require registration. It is very difficult to conduct research on the unregistered population, as refugees are unlikely to talk to officials. A prominent study on health care access by Doocy et al., attempted to survey both registered and unregistered refugees, but only 6% of their refugee sample was unregistered. (2015). Registration status likely affects a refugee's access to psychosocial care by reducing the number of clinics they can access and added stress, but it is not studied enough to know for certain.

If the estimate of unregistered refugees is correct, 1.4 million Syrian refugees are in Jordan, or about 1 in 6 people in the country are Syrian refugees and have arrived in the past 6 years. For any country, this quick increase would be damaging to public services and infrastructure. It is particularly difficult after a previous wave of refugees from Iraq a decade earlier. In Figure 3 below, a conservative estimate by the World Bank shows a population increase of nearly 50% in the past 15 years. The aforementioned Jordanian government census indicates a much larger increase in the population. Before the crisis, Jordanians could access public health services easily at little to no cost, but the population increase has led to long lines and decreased access. In fact, fees for refugees to access care increased in 2014. The crisis has seen many NGOs come into Jordan to provide services, but the public infrastructure is still seeing demand outpace the services available (Doocy, 2015).

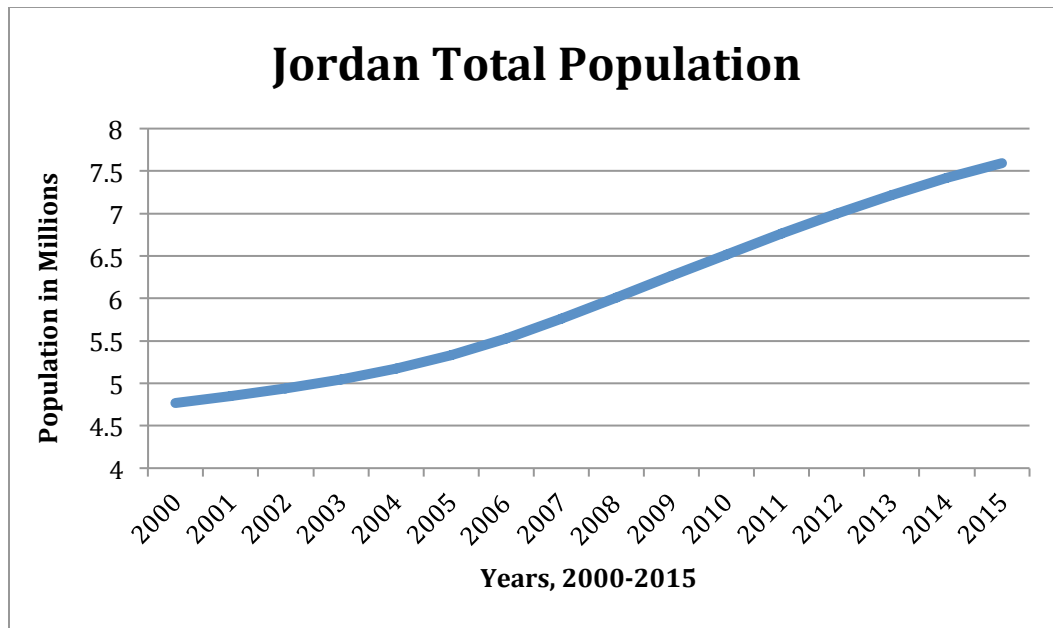


Figure 3 World Bank Data, 2017

VI. Public Health in the Syrian Conflict

Traditional crisis response places communicable disease and malnutrition as the utmost priority (Banatvala & Zwi, 2000). These issues are loud killers (as opposed to “silent killers,” discussed below) that evoke responses from the international community.

Due to adequate vaccine coverage over the past 25 years, Syria made life-threatening communicable diseases obsolete or only present in isolated areas of the country.

Compared to other refugee crises, the high pre-war vaccination rate in Syria and strong health systems of neighboring countries successfully controlled most communicable disease in recent years, and the international community focused closely on the outbreaks that did occur (Aylward & Alwan 2014; Ismail, 2016). The breakdown in public health infrastructure as a result of the civil war gave rise to diseases not detected at this level in a long time, such as polio, tuberculosis, and cutaneous leishmaniasis. Recently, the World Health Organization (WHO) has worked with both the regime and rebel groups in order to combat the first outbreaks of wild Poliovirus since 1999. The detection of 35 cases in Aleppo and Deir ez-Zor in 2013 was met with a rapid response of emergency vaccine dispersal, though hampered by a war-torn health system, that has led to no more reported polio cases through 2016 (WHO, 2014). Other less-common diseases, such as leishmaniasis (also known as the Aleppo boil or Aleppo Evil, pictured below) have spread outside of their endemic areas, causing increases of up to 96% in Lebanon after the crisis began (Al-Salem et., al 2016). In absolute terms, cases of leishmaniasis have nearly doubled from an average of 23,000 between 2004 and 2008 to 53,000 cases in 2013 (Hallett, 2016).



A Syrian Boy receives an injection into an "Aleppo Boil" (Hallett, 2016)

There will continue to be effects of this sort long after the crisis; however, the alarm has not been sounded as loudly for mental health and non-communicable disease in this crisis because they do not manifest as physically as communicable diseases. These two issues, sometimes called “silent killers” have not experienced as swift of a response, even though they are also inflicting suffering upon the Syrian refugee population (Doctors Without Borders, 2016). Between the years of 2000-2030, the Middle East region is expected to undergo a 163% increase in the amount of individuals with diabetes, and similar increases were expected in other non-communicable diseases (NCDs) (Wild, Roglic, Green, Scree & King 2004, p. 1049). Most of the NCDs are chronic diseases that are unable be cured. Consequently, these diseases place a much larger financial burden on individuals. In fact, Kankeu et al., showed that the direct and indirect costs of living with NCDs in low and middle income countries are more likely to be absorbed by households than the government, creating lifetime financial hardship (2013, p. 1-2). As mentioned in the previous discussion of global mental health, many similarities exist between NCDs and

mental illness. In fact, many researchers today include mental illness underneath the umbrella term of NCD (Ngo, et al., 2013). These increasing burdens did not stop for the Syrian people with the outbreak of the Syrian Civil War in 2011, and health care system improvement in Jordan must treat these issues as one.

The NCD, and more specifically, chronic disease burden is relevant when analyzing mental health and psychosocial care capacity in the conflict for two reasons. First, successful interventions for both chronic disease and depression that improve patients' quality of life are generally much more resource and time intensive than basic communicable disease care. It is important to note that successful interventions are not always physician based. Nurses and other health workers providing "collaborative care" in a primary care setting have shown positive results in improving the lives of patients with depression, though there have been few studies completed outside of the United States (Katon et al., 2010; Bower et al., 2006). Second, extensive studies show high comorbidity rates between chronic disease and depression (It is important to note that depression can also be a chronic disease, however). Not only is it more likely for someone with chronic disease or depression to develop the other, but also two or more of the illnesses together greatly decrease the patients' quality of life. (Moussavi et al., 2007). There are also similarities in patients' care-seeking behavior during this crisis for chronic disease and mental illness. Refugees are less likely to access care for chronic diseases and mental illness than communicable disease (Doocy, 2015). Though this paper focuses on mental health and psychosocial care, Syrian refugees' bodies are undergoing changes from communicable disease, non-communicable disease, and stress-related illnesses. This paper sees mental health as an integrated part of overall refugee wellbeing. Thus, it calls for a

contextualization of illness through not only societal factors but also through biological factors that could be affecting the refugee. Mental health and “physical” health are not separated.

Psychosocial care before the crisis and today

Even prior to the start of the Civil War, Syrians with mental illness did not have many options for treatment. Okasha et al., estimated that in 2007 the number of psychiatrists, psychologists, and social workers per 100,000 were 0.5, 0.5, and close to 0, respectively (2012). Mental health and psychosocial services were not available outside of large cities, mainly Damascus. Even in Damascus, access was often limited due to long wait times and cost. The reasons behind the scarcity and centralization of mental health services are two-fold. First, mental health was not emphasized in medical education. This led to a low number of mental health professionals/specialists in Syria. The MHPSS specialists congregated in the urban areas of Syria, mostly around Damascus, preventing many Syrians throughout the country from accessing MHPSS care. Secondly and perhaps most importantly, primary health care workers did not treat mental health as it was believed to be a fundamentally different kind of illness than they are equipped to treat. Similarly, community-based and outpatient mental health services in the form of “community centres, outreach, psycho-education, safe spaces, and psychosocial activities in schools” did not exist (Eloul et al, 2013, 343). None of these issues are unique or unusual in low or middle-income countries. Oftentimes, mental health services are the last health care services to be developed and integrated into primary health care (Saraceno et al., 2007). Likely due to the longstanding separation of mental illness from physical illness,

Syria made mental health its last priority as it worked to improve its health system over the past 20 years, leading to a dismal mental health system that relied on institutionalizing the mentally ill. The destruction of health services within Syria as both a method of waging war and as collateral damage has already been addressed at length, but it should be noted independently that the current mental health care infrastructure in Syria is nonexistent. This leaves victims of torture, refugees, and internally displaced persons nowhere to go for guided medical treatment. A strong mental health system was long overdue in Syria, and the destruction of the entire system will likely set the development of mental health infrastructure back decades.

As of 2007 in Jordan, mental health and psychosocial care dealt with similar issues around urban centralization of services and health worker shortages. The amount of psychiatrists, psychologists, and social workers per 100,000 were, in some occupations, nearly double or quadruple that of Syria, but in absolute terms, there were still few mental health care providers (Okasha et al., 2012). It is interesting that Jordan had more mental health professionals prior to the crisis, but likely not significant for Syrian refugees. It is possible that more mental health clinics were established in Jordan due to influence from Western governments and development agencies, or as a response to the large number of refugees the country was already hosting. Regardless, the population of Jordan increased by a fifth after the Syrian civil war began, calling for a large increase in social services throughout the country. When I asked about the current status of mental health and psychosocial care, a Jordanian sociologist noted that a UNHCR survey in Jordan found that only 13.3% of respondents accessed care for their mental health issues, with the main reason being wait times and long distances to the MHPSS clinics. Overcoming longstanding

stigma around mental illness and promoting treatment, especially in primary care clinics, takes time. Therefore, MHPSS interventions should be made available to Syrian refugees while in Jordan or another host country. In the future, a strong commitment to Syrian and Jordanian health care infrastructure must be made from the international community, with MHPSS being included.

VII. Results

Prior to this section, the overview of the refugee situation has been discussed, and the importance of psychosocial care, both in general and in relation to this crisis, has been argued. While these topics are meaningful on their own, I provide the problems of providing psychosocial care in the following sections to create a framework for policymakers to improve their response to this crisis and crises in the future. The interviews, literature reviews, and training manuals that I conducted and analyzed also brought to light innovative responses and solutions to these problems. I included these within my results to provide a full picture of the crisis and to highlight the role the qualitative, holistic approach in global health research plays in improving crisis response. As I introduce interviewees, all names are pseudonyms to protect their identity. All interviewees would not consent to interview unless their real names were excluded from the results.

Problems of Psychosocial Care in the Syrian Crisis

Many of the issues in psychosocial care in the Syrian crisis are related and exacerbate each other, but the results of this research have fallen into four main categories: the stigma associated with mental illness and stress-related conditions, the view of mental health and psychosocial care as non-traditional medicine, the sheer scale of psychosocial care needed, and legal issues of providing these services in Jordan.

Stigma surrounding mental illness has been well documented across cultures and around the world (WHO, 2001). As a Westerner, it is difficult and inappropriate for me to

posit reasons why any culture, including Syrian or Jordanian, may or may not contribute more to stigma than other cultures. It is more important to note, however, that interviewees treating Syrian refugees across specialties and occupations continually repeated that stigma prevents many of their patients from coming to them for mental health care or voicing their own concerns during a physical exam or check-up. The stigma of mental health can be separated, across cultures, into two dimensions: public stigma and self-stigma, which are explained below in Figure 4 (Corrigan & Kleinlein, 2005). Corrigan argues that stigma cannot be seen solely as a medical issue that can be treated, stating:

When viewed in terms of the prejudice and discrimination experienced by other out-groups, such as ethnicity and gender, stigma is better understood as an issue of social injustice. On the basis of sociological research, a social injustice perspective argues that many of the lost opportunities experienced by people with mental illness result from the difference and defects suggested by stigma. Exaggerated notions of group difference result in less power for people with mental illness (2004, p. 624).

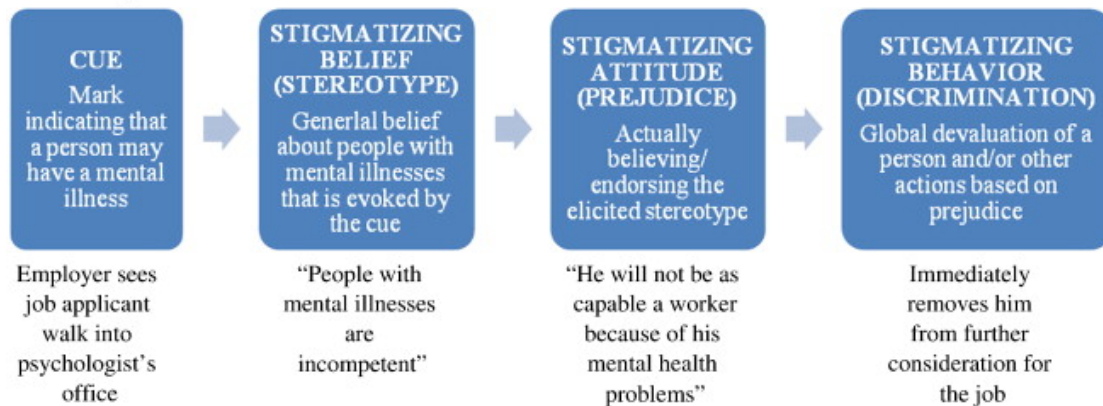
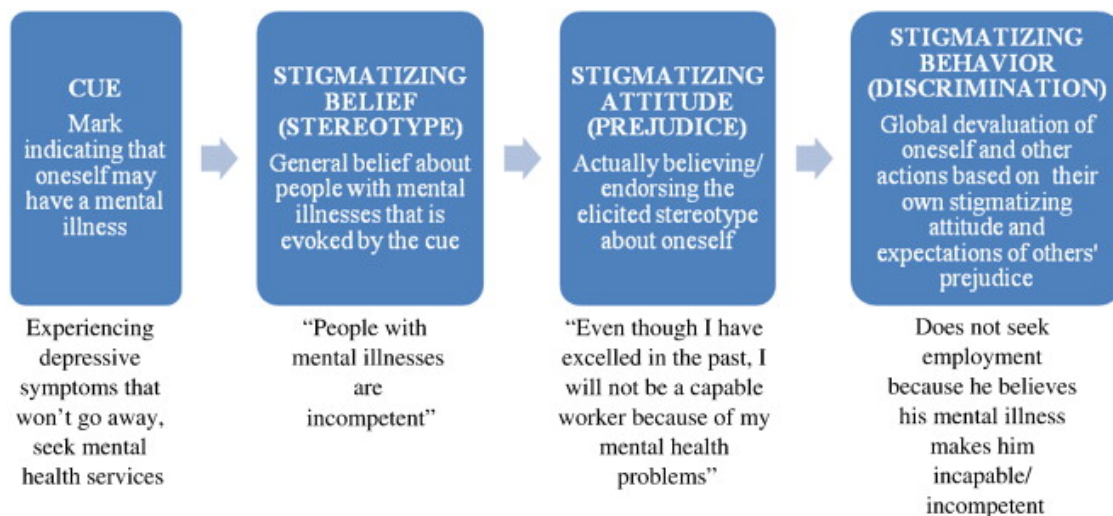
Public Stigma**Self-Stigma**

Figure 4: Retrieved from Abdullah & Brown (2011)

A Syrian physician, Dr. Abadi, stated that he felt certain issues around secrecy and family honor prevented refugees from speaking out about mental health concerns. A patriarchal society can especially prevent women from seeking treatment, as well as men who feel that they would be seen as weak. This concern is echoed by Abdullah and Brown as they state that "for Middle Eastern cultures in which concealing emotions is valued, this may contribute to stigma towards mental health services and those who seek them (2011, p. 943-944). Continually, several doctors in Jordan who treated depressed patients

discussed the challenges of bringing up mental illness in the clinical setting. While in the United States a doctor may ask a patient if they are feeling depressed, doctors treating Syrian refugees stated that they had to dance around the issue, and they could not use medical diagnostic terms. An example Dr. Abadi gave me was as follows:

I ask the patient if she has been crying uncontrollably, having trouble sleeping or eating, or if she has trouble doing basic chores. It is difficult to ask questions about what is normal and what is not for refugees. They are already far from home and nothing is normal. If I were to say she was depressed, she would be concerned about the family with her thinking she had something wrong with her.

In fact, he used the Arabic word “ghareeb” to describe the way the patient would feel if diagnosed in the clinic with mental illness, which is defined by Hans-Wehr as “strange, foreign, alien” (1970, p. 562). The theory around stigma is important to understand how it is internalized, but this story from Dr. Abadi is the most gripping. It shows the cultural challenges of practicing medicine, especially MHPSS. Mental health professionals must work to accurately diagnose and explain mental illness to their patients, but they must also take care to prevent the patient from feeling as if they are strange because they have a mental illness. It was obvious that the doctor felt this latter burden, greatly. It may be unfair to make a health care professional responsible for broad, societal changes; however, the first step is undoubtedly through health services and a crisis response that actively strives to reduce the stigma around mental illness. The universality of stigma and the

environment in which the health system of Jordan developed should be remembered in the discussion of the next problem below.

Though also a universal concept, the clinical separation of mental health from “physical” ailments was continually the biggest barrier that I saw in my research to mental health and psychosocial care for Syrian refugees. As stated previously, primary care should serve as the second line of defense, behind broader community support of mental illness, in helping refugees who have undergone traumatic or violent experiences. In interviews with two primary care physicians, Dr. Hamid and Dr. Khoury, at the biggest health center in Amman, I repeatedly heard that they felt that they were simply not qualified to provide mental health support or they “do not do that type of care.” They are correct in that some specialty care should be reserved for people with severe mental illness, but the physicians made it clear that they were not comfortable providing treatment to the majority of their patients. Dr. Khoury and Dr. Hamid stated that they received their information about treating Syrian refugees with PTSD or depression from the WHO’s Mental Health Gap Action Program (MHGAP) document that seeks to improve mental health care in areas where specialist care is nonexistent or limited, which I was provided with. They stated that treatment provided was largely through medication in the form of antipsychotics and antidepressants. Contrastingly, the MHGAP document recommends, as can be seen below in Figure 5, that medication is only part of a larger program of mental health care that focuses on social support and psychosocial care (WHO, 2010 p. 25). These crowded clinical settings in a resource-stressed area are defaulting to the least time consuming method of treatment, antidepressants. Not only at odds with the treatment guidelines, it also shows that the doctors are not practicing based on the guidelines that they read. It is possible

they lied to me, but in my opinion, it is more plausible that they have habits of practicing medicine that cannot be changed by a book or pamphlet. The interviews with primary care doctors on the topic of treatment guidelines clearly showed that medical education does not include all MHPSS treatment possibilities, only prescription-based treatment. In interviews with mental health specialists, they seemed much more open and knowledgeable about other forms of care. They were open to psychoeducation, group therapy, and all other forms of care mentioned in Figure 5.



- » Psychoeducation. » **DEP 2.1**
- » Address current psychosocial stressors. » **DEP 2.2**
- » Reactivate social networks. » **DEP 2.3**
- » Consider antidepressants.  » **DEP 3**
- » If available, consider interpersonal therapy, behavioural activation or cognitive behavioural therapy. » **INT**
- » If available, consider adjunct treatments: structured physical activity programme » **DEP 2.4**, relaxation training or problem-solving treatment. » **INT**
- » **DO NOT** manage the complaint with injections or other ineffective treatments (e.g. vitamins). 
- » Offer regular follow-up. » **DEP 2.5**

Figure 5: Retrieved from WHO MHGAP Depression Treatment Recommendations (2010, p. 25)

A high-ranking Ministry of Health official with knowledge of all MOH operations in Jordan, Dr. Sleiman, informed me that feelings of incompetency with regards to mental health care among PCPs was quite common. He attributed it to the fact that most of the mental health work done in Jordan is completed by NGOs, and the MOH had only recently

established a center for psychiatric treatment that was not focused on institutionalizing patients. Dr. Sleiman's body language told me that NGOs were relieving the MOH of a heavy burden, and I was told that if I wanted to know about mental health, I should ask them. The separation of traditional MOH services and mental health services exacerbates the divide between physical illness and mental illness. In the clinical setting, Dr. Sleiman acknowledged that most mental health issues only come up in the context of other illnesses, especially non-communicable diseases such as diabetes or hypertension where the patient visits the doctor often. As previously mentioned, non-communicable and chronic diseases often exacerbate or cause mental health issues due to the extra stress they place on a patient. During a visit to the UNHCR, I was provided with training documents that they use to inform health care providers about treating non-communicable disease in resource-scarce situations. The document, or "toolkit," as it is called, fails to mention screening for mental illness or other signs of distress except for when a patient has multiple non-communicable diseases. In this instance, it devotes one line to inquiring about "social or psychological problems" (PCE International, 2015 p. 19).

When pressed about psychosocial programs that they refer patients to, primary care doctors at an MOH and an NGO clinic stated they refer patients to secondary or tertiary care only in case of extreme mental illness due to overcrowding at the mental health clinics. The doctors were not fully aware of non-traditional forms of mental health treatment, such as psychosocial care. Thus, it can be inferred that many people are being stuck in the middle—not sick enough to warrant urgent treatment, but not well connected or informed enough by their PCP to seek out psychosocial programs that could improve their quality of life.

It should also be mentioned that specialists in the treatment of mental illness possess some biases that came to light in interviews, as well. Dr. Maalouf and Dr. Seif stated that they felt PCPs were under-qualified to treat severe mental illness, but it was clear that they believed a patient was better off when treated for mental illness in some form, and other types of care helped them concentrate on the patients who need it the most. Probably due to this view, specialists were much more knowledgeable about and receptive to psychosocial care than PCPs. When asked about treatments such as group therapy and listening-sessions that help patients with moderate PTSD or depression, both specialists encouraged these treatments as a means of reducing the caseload on themselves in order to spend more time with severely ill patients. Though this is not ideal, this fits the pyramid models of MHPSS that were discussed in the Global Mental Health and Psychosocial Care section. Overall, psychosocial care was seen as a complement to the specialist's services and not a replacement.

The third problem brought to light in this research has been the overwhelming demand on both Syria's and host countries' health systems. The number of refugees in Jordan and the estimated rate of psychiatric illness has been previously mentioned, but it is worth repeating here: 1.4 million registered and unregistered refugees are in Jordan, and a conservative estimate of 33.5% of the population has clinically prominent PTSD (Alpak et al., 2015). High numbers of mental illness and crowding of health services results in reduction in access to care. Dr. Khoury (the PCP) stated that she has less than five minutes per patient on a normal day since the Syrian crisis began. This left little time for her to discuss mental health with the patient, and it prevents her from explaining things at a "level at which I am sure they understand."

As mentioned at the beginning of the paper, traditional crisis response has led to rapid response towards malnutrition and communicable disease that mismatches the current burden of mental illness and chronic disease that many Syrian refugees are experiencing. NGOs and the UNHCR have scaled up their deployment of mental health professionals, but the current number of professionals is not enough. Dr. Seif, who treats Syrian refugees regularly, argued that NGOs are attempting to scale up the specialists in the country believing that they will one day have enough mental health support to overcome the traumatic events that Syrian refugees have gone through. This is “unrealistic” and “misguided.” Instead, he believes that NGOs should work to bring more mental health doctors into Jordan, but they must also focus on “teaching people to their own personalities and issues and go from there” on a massive level. He stated that this requires an integrated, well-planned mental health system that provides everyone some sort of treatment while reserving specialist appointments for the extremely mentally ill. On the other hand, Dr. Amery, a specialist at a dedicated mental health center (which provides psychosocial care) in Jordan believed that some psychosocial centers were undertrained and failed to provide the services at levels that were beneficial. Her concerns are valid, and it is the most common argument I heard against the integrated mental health and psychosocial care model. In response to this argument, Dr. Seif and others argue it is difficult to quantify the positive impact of services like group therapy or active listening sessions and that low-skilled psychosocial care work is not harmful to others. Additionally, Dr. Amery’s critique does not take into account the entire need among the Syrian population. Mental health care as a crisis response must be done on a population level with the amount of traumatic events that have occurred and continue to occur in the Syrian civil war.

The large, international response led to more foreign MHPSS workers entering the country to increase the amount of care available. Some of the specific cultural issues in treating mental health have already been discussed, but from a broader perspective, mental health professionals must relate closely to their patients and understand their home life more than most other health care workers. This raises the question of how well mental health infrastructure imported from the US or Europe is able to care for patients in Jordan. All of the doctors that I interviewed were Syrian or Jordanian, and I believe further research should be done on how well foreign doctors are able to connect with patients in mental health care.

Though I was unable to interview any non-Jordanian or Syrian doctors, I analyzed a UNHCR training manual for mental health workers not familiar with Arabic language or Syrian culture. It aims to give 40-pages of explanation and guidelines for MHPSS professionals working with refugees. Some main tenets of successful psychosocial care that I discussed throughout this paper were upheld, especially the importance of socioeconomic context and mental health treatment. However, the document also reveals some issues with bringing in health workers unfamiliar with the language and culture. Figure 6, below, shows an attempt by the training manual to place mental illness categories around Syrian-dialect Arabic phrases. Having studied Syrian dialect myself, I understand how confusing some of the expressions can be in the dialect, but it is concerning that the chart must place these phrases into boxes. This chart (which goes on for several pages) shows how difficult it is to work as a mental health professional in a foreign country, while also reinforcing the importance of Syria and Jordan investing in local mental health professionals in the long-term.

Arabic term or phrase	Transcription	Literal translations	Emotions, thoughts and physical symptoms that may be conveyed through these expressions
متضايق كثير هالفترة حاسس حالي متضايق ضايح نفسى مخنوقة	- Meddayyek ketir hal fatra - Haassess haalii meddayyek - Dayej - Nafsi makhnouka	- I am very annoyed these days - I feel annoyed - To be cramped - My psyche is suffocating	- Rumination tiredness, physical aches, constriction in the chest, repeated sighing - Unpleasant feelings in the chest, hopelessness, boredom
حاسس روحي عم تطلع	- Hassess rouhi 'am tetla'	- I feel my soul is going out	- Dysphoric mood, sadness - Inability to cope, being fed up - Worry, being pessimistic
قلبي- مقبوض انعمى على قلبي	- Qalb maqboud - In'ama 'ala kalbi	- Squeezed heart - Blindness got to my heart ¹	- Dysphoria - Sadness - Worry, being pessimistic
تعبان نفسيًا- حاسس حالي تعبانه- حالتي تعبانه- نفس تعبانه	- Taeban nafseyan - Hassess halii ta3ban - Halti taebaneh - Nafs ta'bana	- Fatigued self/soul	- Undifferentiated anxiety and depression symptoms, tiredness, fatigue
-ما قادر اتحمل الضغط علي كثير- مو قادر ركز من الضغوطات -	- Ma ader athammel - El daght 'alayy ketiir - Mou kaader rakkezz men el doghoutaat	- Can't bear it anymore - The pressure on me is too much - Can't concentrate because of the pressure	- Feelings of being under extreme stress or extreme pressure - Helplessness
فرطت-	- Faratit	- I am in pieces	- General state of stress, sadness, extreme tiredness, inability to open up and to control oneself, or to hold oneself together
و الله مو شايف قدامي-	- Wallah mou shayef oddaamii	- By God, I can't see in front of me	- General state of stress, feelings of loss of options, loss of ability to project into the future, - Confusion, hopelessness

Figure 6: Common Expressions and Idioms of Distress in Arabic (Retrieved from Hassan, et al., 2015)

Legal issues were another problem that affected the implementation of mental health and psychosocial care. Dr. Maalouf, who was also interviewed as a mental health specialist, is the Syrian director of a large mental health program operating in Turkey, Jordan, Syria and Lebanon. He stated that the two biggest barriers to increasing the care they offer in Jordan are regulations around physician licensure and pharmaceutical drugs. Though the official regulations are murky, he told me that Jordan prevents some mental health practitioners from working in Jordan long-term unless they possess Jordanian citizenship. He was referring specifically to the barriers that his NGO and others like it

have faced, and he posited that Jordan wanted to keep the job market strong for any Jordanian doctors. I asked Dr. Maalouf whether this happened to medical doctors who were not specialists in mental health care, and he felt that mental health professionals were easier to ban since the manifestations of a lack of treatment are not as physical as other illnesses. There are ways around this, especially for short periods of time that are similar to mission trips, or NGOs with “wasta,” or clout with important officials, but it is troubling that Jordan is preventing access to mental health services due to this general rule. When Jordanian officials do allow US doctors to practice in the country, admitting privileges can be curtailed, according to the Dr. Maalouf. If turning to local mental health professionals was an option, I would absolutely advocate for it as discussed above, but the large need for MHPSS demands that others from outside the country provide services to fill the gap until capacity can be built in the country. Jordan had a very low rate of mental health workers before the crisis; qualified Jordanian doctors will not suddenly appear only because international aid money will now pay for them. NGOs should commit to educating and building capacity for more Jordanian mental health professionals in the country.

Dr. Maalouf also believes that the cost of the main psychiatric prescription drugs that they use are much more expensive in Jordan for NGOs like themselves. Impressively, he says that the prices oftentimes double or triple US prices for the same drugs. Lastly, the issue of registration is a legal issue that affects half of the Syrian refugees in Jordan. Some health care centers only provide free medicine or care to registered refugees, preventing access to undocumented Syrians. While Jordan is undoubtedly one of the most welcoming host countries for Syrian refugees, there are several regulations that could be removed to increase access to mental health and psychosocial care.

Emerging Solutions

Throughout my research, innovations in medical care and public health crisis response were brought up or discovered. Though I have been critical of the international response at points in this paper, this crisis is one of the first times mental health has been accepted as part of international medical response. As discussed previously, mental health has historically been relegated to the lowest priority, and I have hopes that this will no longer be the case after the Syrian crisis due to the emphasis on MHPSS improvements. If this trend continues, mental health and psychosocial care could be seen as a first line response for populations such as Syrian refugees in the future.

Perhaps the most important development was the use of telepsychiatry. Telepsychiatry, or more broadly, telehealth, is a form of care that connects the patient and care provider over video chat. It allows areas with few mental health doctors, such as Jordan or Syria, to expand the number of individuals who see patients. Though critiqued for being impersonal, telepsychiatry has shown to be an effective means of providing mental health care (Perle et al., 2011). As Nassan et al., state, the “use of telepsychiatry as a temporary, cost-effective solution for the growing mental health care needs of Syrian patients with PTSD is justified by the complicated and challenging difficulties faced by traditional in-person care” (2015, p. 866). The patients travel to a clinic, where they are brought into a room with a screen and webcam, as seen in the picture below. The main logistical issues stem from the lack of high speed internet in some areas, but technological improvements are slowly improving this issue. Dr. Seif treated patients inside Syria and Jordan from the US through telepsychiatry weekly, and he had travelled to Jordan to treat

refugees in-person, as well. He believes that telepsychiatry is not ideal, but he provides specialist care in parts of Syria that are too dangerous for him to travel to or alleviate the wait times at a clinic in Jordan. The use of Syrian doctors living abroad is particularly interesting, as it circumvents many of the cultural and licensure issues around importing doctors into Syria or Jordan.



[A Syrian refugee in Kurdistan talks with a doctor in the United States \(VSee, 2014\)](#)

Another proposed solution recently received attention on NPR by using the internet not to treat, but to train using WhatsApp or Skype (Amos, 2017). The trainings, facilitated by Syrian mental health professionals residing in the US, provide resources to Syrian refugees who would like to support others through “active listening,” which is a form of psychological first aid (Snider et al., 2011). If this is successful, it could be a significant step towards providing social support that could handle the size of the Syrian population. Psychological first aid can significantly improve the mental health of the population. It will

build capacity for community health workers to better intervene and improve the lives of many individuals suffering from PTSD or depression. The situation in Syria that has followed Syrian refugees around the world for the past six years is dire, but the innovations born out resulting from the crisis are improving the lives of Syrian refugees and will serve as a model for future refugee crises.

VIII. Conclusion

Violence and trauma in the Syrian civil war led to high rates of mental illness and distress in the Syrian refugee crisis. When broadly defined, psychosocial care is a holistic approach to improving mental health, and it can be integrated within a larger network of primary, secondary, and tertiary interventions that allow for severely mentally ill patients to see specialists first when health systems are overcrowded. Additionally, it takes into account cultural issues that traditional treatment approaches do not. Over the long term, it serves to reduce stigma and build social support within a community for people with mental illness. Though there are many positives, some barriers to psychosocial care and, more broadly, mental health care exist. Mental health treatment is a high-resource type of health care requiring long amounts of time and a personal relationship with the patient, and there are long-standing stigmas around mental illness that are difficult to overcome.

Several issues should be considered for further research in this area. First, the data did not give much insight into how well the dissemination of information occurs in the health system. Implementing a broad, new program that hopes to induce change in the societal stigma around mental health is difficult, and disseminating proper information to the entire system is important. Though raised as an issue, more studies should be done to understand the effect of both non-local health care workers providing mental health care and the efficacy of telepsychiatry as a replacement of face-to-face contact in crisis response mental health care. Additionally, similar analyses in Lebanon and Turkey would be helpful in understanding the response in wider terms. Turkey would be particularly interesting, as it has a stronger health system and relies less on the international community for aid

support. Also, an interview-based study on issues around accessing dedicated mental health facilities should be completed. I discuss the traditional separation of mental illness and physical illness extensively, and it would be quite meaningful to better understand how the Syrian refugee community views a stand-alone mental health clinic versus an integrated clinic with both primary care and mental health care.

Overall, this study contributed to a large gap in literature on MHPSS in the Syrian refugee conflict in Jordan by exposing issues around the implementation of the framework and emerging new responses. The main findings of this study, as well as the argument for psychosocial care in this crisis, will hopefully be used by health policy makers to understand and improve the current situation for Syrian refugees in Jordan, and humanitarian crisis response as a whole.

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